FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022541

Facility Name: CONTINENTAL CARE CENTER

Address: 5336 N. WESTERN AVE (Number) CHICAGO (City) 60625 (Zip Code)

County: COOK

Telephone Number: (773) 271-5600 **Fax #** (773) 271-2144

IDPA ID Number: 362871756001

Date of Initial License for Current Owners: 1976

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) MARVIN FOX, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	208	Skilled (SNF)	208	75,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	208	TOTALS	208	75,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	28,551	2,498	5,385	36,434	8
9	SNF/PED					9
10	ICF	22,052	957		23,009	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,603	3,455	5,385	59,443	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.30%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 4061

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	271,294	20,634	13,657	305,585		305,585	28,999	334,584			1
2	Food Purchase		291,187		291,187	(31,755)	259,432	(169)	259,263			2
3	Housekeeping	166,872	38,994		205,866		205,866		205,866			3
4	Laundry	73,989	25,811		99,800		99,800		99,800			4
5	Heat and Other Utilities			167,261	167,261		167,261	1,401	168,662			5
6	Maintenance	74,030		89,967	163,997		163,997	(19,001)	144,996			6
7	Other (specify):*							1,992	1,992			7
8	**TOTAL General Services**	586,185	376,626	270,885	1,233,696	(31,755)	1,201,941	13,222	1,215,163			8
	B. Health Care and Programs											
9	Medical Director			19,800	19,800		19,800		19,800			9
10	Nursing and Medical Records	2,085,053	206,038	357,465	2,648,556		2,648,556	(63,507)	2,585,049			10
10a	Therapy	100,336	796	7,606	108,738		108,738	(634)	108,104			10a
11	Activities	72,380	9,403	2,444	84,227		84,227		84,227			11
12	Social Services	71,125		2,317	73,442		73,442		73,442			12
13	Nurse Aide Training											13
14	Program Transportation			3,411	3,411		3,411		3,411			14
15	Other (specify):*							4,338	4,338			15
16	**TOTAL Health Care and Programs**	2,328,894	216,237	393,043	2,938,174		2,938,174	(59,803)	2,878,371			16
	C. General Administration											
17	Administrative	122,809		592,309	715,118		715,118	(374,332)	340,786			17
18	Directors Fees											18
19	Professional Services			110,469	110,469	(52,540)	57,929	2,161	60,090			19
20	Dues, Fees, Subscriptions & Promotions			163,597	163,597		163,597	(81,029)	82,568			20
21	Clerical & General Office Expenses	187,057	42,082	214,545	443,684		443,684	(31,266)	412,418			21
22	Employee Benefits & Payroll Taxes			534,780	534,780	31,755	566,535		566,535			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,054	3,054		3,054	79	3,133			24
25	Other Admin. Staff Transportation			1,990	1,990		1,990		1,990			25
26	Insurance-Prop.Liab.Malpractice			143,274	143,274		143,274	21	143,295			26
27	Other (specify):*							43,349	43,349			27
28	**TOTAL General Administration**	309,866	42,082	1,764,018	2,115,966	(20,785)	2,095,181	(441,017)	1,654,164			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,224,945	634,945	2,427,946	6,287,836	(52,540)	6,235,296	(487,598)	5,747,698			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CONTINENTAL CARE CENTER #0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			162,695	162,695		162,695	15,400	178,095			30
31	Amortization of Pre-Op. & Org.			9,055	9,055		9,055		9,055			31
32	Interest			344,151	344,151		344,151	(119,330)	224,821			32
33	Real Estate Taxes			254,591	254,591	52,540	307,131		307,131			33
34	Rent-Facility & Grounds							13,356	13,356			34
35	Rent-Equipment & Vehicles			9,698	9,698		9,698	1,278	10,976			35
36	Other (specify):*							(3,697)	(3,697)			36
37	TOTAL Ownership			780,190	780,190	52,540	832,730	(92,993)	739,737			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatic											38
39	Ancillary Service Centers	153,383	344,664	913,311	1,411,358		1,411,358	(77,708)	1,333,650			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,880	113,880		113,880		113,880			42
43	Other (specify):*	25,137			25,137		25,137	(25,137)				43
44	TOTAL Special Cost Centers	178,520	344,664	1,027,191	1,550,375		1,550,375	(102,845)	1,447,530			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,403,465	979,609	4,235,327	8,618,401		8,618,401	(683,436)	7,934,965			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Numb CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	896	30		9
10	Interest and Other Investment Income	(123,757)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(169)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(13,520)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(135,300)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,291)	20		28
29	Other-Attach Schedule	(145,946)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (424,087)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(259,349)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (259,349)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (683,436)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
CONTINENTAL CARE CENTER
ID# 0022541
Report Period Beginning: 01/01/01
Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank charges	$ (4,435)	21	1
2	Illinois Council COPE	(1,636)	20	2
3	VA expense	(890)	10	3
4	Meals & entertainment	(503)	21	4
5	State replacement tax (SRT)	(10,786)	21	5
6	Marketing salary	(25,137)	43	6
7	Advertising	(57,969)	20	7
8	Out of c/r period legal fees	(258)	19	8
9	Missing invoice legal fee (8/31/01)	(330)	19	9
10	Capitalized R&M (2000)	(7,639)	06	10
11	Capitalized R&M (2001)	(11,742)	06	11
12	Non-allowable seminar expense	(345)	24	12
13	Use tax	(1,263)	21	13
14	Community education	(23,013)	20	14
15				15
16				16
17				17
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19				19
20				20
21				21
22				22
23				23
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95				95
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97				97
98				98
99				99
100				100
	Total	(145,946)		

STATE OF ILLINOIS

Summary A

Facility Name & ID Numbe CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				1,165	117		72			27,645		28,999	1
2	Food Purchase	(169)											(169)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,143			258						1,401	5
6	Maintenance	(19,381)		46	253		172	(91)					(19,001)	6
7	Other (specify):*				1,445	2		545					1,992	7
8	**TOTAL General Services**	(19,550)		1,189	2,863	119	430	526			27,645		13,222	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(890)		17,799			6,593				(87,009)		(63,507)	10
10a	Therapy								(307)	(327)			(634)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			2,922			1,416						4,338	15
16	**TOTAL Health Care and Progra**	(890)		20,721			8,009		(307)	(327)	(87,009)		(59,803)	16
	C. General Administration													
17	Administrative			95,851	(365,611)	(47,662)	54,222	(111,132)					(374,332)	17
18	Directors Fees													18
19	Professional Services	(588)		5,763		(7,727)	4,713						2,161	19
20	Fees, Subscriptions & Promotions	(88,909)		5,665		42	2,173						(81,029)	20
21	Clerical & General Office Expens	(165,807)		80,975		11,587	41,979						(31,266)	21
22	Employee Benefits & Payroll Tax													22
23	Inservice Training & Education													23
24	Travel and Seminar	(345)		162			262						79	24
25	Other Admin. Staff Transportatior													25
26	Insurance-Prop.Liab.Malpractice			19			2						21	26
27	Other (specify):*			24,010		379	18,960						43,349	27
28	**TOTAL General Administration**	(255,649)		212,445	(365,611)	(43,381)	122,311	(111,132)					(441,017)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(276,089)		234,355	(362,748)	(43,262)	130,750	(110,606)	(307)	(327)	(59,364)		(487,598)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	896		12,203		1,868	433						15,400	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(123,757)		3,000		1,432	(5)						(119,330)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			9,333			4,023						13,356	34
35	Rent-Equipment & Vehicles				974		304						1,278	35
36	Other (specify):*					(3,697)							(3,697)	36
37	**TOTAL Ownership**	(122,861)		24,536	974	(397)	4,755						(92,993)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(34,563)	(31,584)	(11,561)		(77,708)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(25,137)											(25,137)	43
44	**TOTAL Special Cost Centers**	(25,137)							(34,563)	(31,584)	(11,561)		(102,845)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(424,087)		258,891	(361,774)	(43,659)	135,505	(110,606)	(34,870)	(31,911)	(70,925)		(683,436)	45

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached		See attached		See attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginni 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	QUALITY CARE MANAGEMENT	100.00%	$ 1,143	$ 1,143	15
16	V	6	REPAIRS AND MAINT.		QUALITY CARE MANAGEMENT	100.00%	46	46	16
17	V	10	SAL-NURSING		QUALITY CARE MANAGEMENT	100.00%	16,307	16,307	17
18	V	10	NURS SAL-M. CLARKE		QUALITY CARE MANAGEMENT	100.00%	1,492	1,492	18
19	V	15	EMP. BEN.-H.C.		QUALITY CARE MANAGEMENT	100.00%	2,922	2,922	19
20	V	17	ADMIN SAL-NON-OWNER		QUALITY CARE MANAGEMENT	100.00%	23,376	23,376	20
21	V	17	ADMIN. SAL.- A. SALTZMAN		QUALITY CARE MANAGEMENT	100.00%	3,967	3,967	21
22	V	17	ADMIN. SAL - B BENOUDIZ		QUALITY CARE MANAGEMENT	100.00%	13,067	13,067	22
23	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	34,376	34,376	23
24	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	4,996	4,996	24
25	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	2,056	2,056	25
26	V	17	ADMIN. SAL. - STEVE VAN CAMP		QUALITY CARE MANAGEMENT	100.00%			26
27	V	17	ADMIN. SAL. - MIKE FILIPPO		QUALITY CARE MANAGEMENT	100.00%	14,013	14,013	27
28	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	5,763	5,763	28
29	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	5,665	5,665	29
30	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	72,427	72,427	30
31	V	21	ACCTG SAL-B. LARIMORE		QUALITY CARE MANAGEMENT	100.00%	5,729	5,729	31
32	V	21	OFFICE SAL-M. CLOCH		QUALITY CARE MANAGEMENT	100.00%	2,819	2,819	32
33	V	24	EDUCATION & SEMINAR		QUALITY CARE MANAGEMENT	100.00%	162	162	33
34	V	26	INSURANCE		QUALITY CARE MANAGEMENT	100.00%	19	19	34
35	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	24,010	24,010	35
36	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	12,203	12,203	36
37	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	3,000	3,000	37
38	V	34	OFFICE RENT-UNRELATED		QUALITY CARE MANAGEMENT	100.00%	9,333	9,333	38
39	Total			$			$ 258,891	$ * 258,891	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginni 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	EQUIPMENT RENTAL	$	QUALITY CARE MANAGEMENT	100.00%	$ 974	$ 974	15
16	V								16
17	V	17	CORPORATE ALLOCATION	365,611	QUALITY CARE MANAGEMENT	100.00%		(365,611)	17
18	V								18
19	V	6	REPAIRS AND MAINT.	2,224	QUALITY CARE MANAGEMENT	100.00%	2,477	253	19
20	V	7	EMP. BEN.-GEN. SERV.		QUALITY CARE MANAGEMENT	100.00%	407	407	20
21	V								21
22	V	1	DIETICIAN SALARIES	5,160	QUALITY CARE MANAGEMENT	100.00%	6,325	1,165	22
23	V	7	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	1,038	1,038	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 372,995			$ 11,221	$ * (361,774)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginni 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN SAL-NON-OWNER	$	QUALITY CARE MANAGEMENT	100.00%	$ 1,069	$ 1,069	15
16	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	3,418	3,418	16
17	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	2,422	2,422	17
18	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	996	996	18
19	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	273	273	19
20	V	17	MGNT FEES-DIRECT ALLOC		QUALITY CARE MANAGEMENT	100.00%	111,131	111,131	20
21	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	42	42	21
22	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	11,587	11,587	22
23	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	379	379	23
24	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	1,868	1,868	24
25	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	1,432	1,432	25
26	V	36	GAIN ON SALE OF ASSETS		QUALITY CARE MANAGEMENT	100.00%	(3,697)	(3,697)	26
27	V								27
28	V	17	CORPORATE ALLOCATION	166,698	QUALITY CARE MANAGEMENT	100.00%		(166,698)	28
29	V	19	COMPUTER SERVICES	8,000	QUALITY CARE MANAGEMENT	100.00%		(8,000)	29
30	V								30
31	V	1	DIETICIAN SALARIES		QUALITY CARE MANAGEMENT	100.00%	117	117	31
32	V	7	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	2	2	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 174,698			$ 131,039	$ * (43,659)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginni 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$ 258	$ 258	15
16	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	172	172	16
17	V	10	NURSING		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	875	875	17
18	V	10	SAL-NURSING-M. CLARKE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	5,718	5,718	18
19	V	15	EMP. BEN.-H.C.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,416	1,416	19
20	V	17	ADMIN SAL-NON-OWNER		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	12,890	12,890	20
21	V	17	ADMIN. SAL.- F. BENJAMIN		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	10,194	10,194	21
22	V	17	ADMIN. SAL - B BENOUDIZ		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	7,346	7,346	22
23	V	17	ADMIN. SAL. - B. CLOCH		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	8,622	8,622	23
24	V	17	ADMIN. SAL. - C. ROSS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,021	1,021	24
25	V	17	ADMIN. SAL - S. VAN CAMP		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	6,339	6,339	25
26	V	17	ADMIN. SAL. - M. FILIPPO		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	7,810	7,810	26
27	V	17	ADMIN. SAL. - J. ELOWE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			27
28	V	19	PROFESSIONAL FEES		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,713	4,713	28
29	V	20	FEES,SUBSCRIPTIONS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2,173	2,173	29
30	V	21	CLERICAL & GENERAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	39,541	39,541	30
31	V	21	SALARIES-ACCTG-B. LARIMORE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2,438	2,438	31
32	V	24	EDUCATION & SEMINAR		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	262	262	32
33	V	26	INSURANCE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2	2	33
34	V	27	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	18,960	18,960	34
35	V	30	DEPRECIATION		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	433	433	35
36	V	32	INTEREST		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	(5)	(5)	36
37	V	34	OFFICE RENT-UNRELATED		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,023	4,023	37
38	V	35	EQUIPMENT RENTAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	304	304	38
39	Total			$			$ 135,505	$ * 135,505	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginni 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	CORP ALLOC/MGMT FEE	111,132	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$	$ (111,132)	15
16	V								16
17	V	6	REPAIRS AND MAINT.	520	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	429	(91)	17
18	V	7	EMP. BEN.-GEN. SERV.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	95	95	18
19	V								19
20	V	1	DIETICIAN SALARIES	1,950	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2,022	72	20
21	V	7	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	450	450	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 113,602			$ 2,996	$ * (110,606)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginni 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 4,590	AT&R II, LLC	100.00%	$ 4,283	$ (307)	15
16	V	39	ANCILLARY REHAB	517,400	AT&R II, LLC	100.00%	482,837	(34,563)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 521,990			$ 487,120	$ * (34,870)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 2,385	Advanced Therapy and Rehab, LLC	100.00%	$ 2,058	$ (327)	15
16	V	39	ANCILLARY REHAB	230,038	Advanced Therapy and Rehab, LLC	100.00%	198,454	(31,584)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 232,423			$ 200,512	$ * (31,911)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginni 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	MEDICAL/TUBE FEED-MDCR	$ 19,252	QUALITY CARE MEDICAL SUPPLY	100.00%	$ 7,691	$ (11,561)	15
16	V	10	MEDICAL SUPPLIES	98,857	QUALITY CARE MEDICAL SUPPLY	100.00%	11,848	(87,009)	16
17	V	1	FOOD SUPPLEMENTS		QUALITY CARE MEDICAL SUPPLY	100.00%	27,645	27,645	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 118,109			$ 47,184	$ * (70,925)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	David Meisels	Exec. Administrator	Administrative	20.00%	See attached	7.5	13.60%	Mgmt fees	$ 60,000	17-1	1
2	Brucha Teitelbaum	Owner	Administrative	2.00%	See attached	1.08	2.70%	Alloc. Salary	7,418	17-7	2
3	Joseph Meisels	Owner	Administrative	2.00%	See attached	4.33	8.66%	Alloc. Salary	3,052	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 70,470		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPOR

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	258,551	8	$ 7,246	$	40,778	$ 1,143	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	258,551	8	290		40,778	46	2
3	10	SAL-NURSING	PATIENT DAYS	258,551	8	103,396	103,396	40,778	16,307	3
4	10	NURS SAL-M. CLARKE	PATIENT DAYS	258,551	8	9,458	9,458	40,778	1,492	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	258,551	8	18,527		40,778	2,922	5
6	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	258,551	8	148,217	148,217	40,778	23,376	6
7	17	ADMIN. SAL.- A. SALTZMAN	DIRECT/PATIENT DAYS		6	22,590	22,590		3,967	7
8	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	258,551	8	82,852	82,852	40,778	13,067	8
9	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	258,551	8	217,962	217,962	40,778	34,376	9
10	17	ADMIN. SAL. - B. TEITELBA	DIRECT/PATIENT DAYS		5	22,566	22,566		4,996	10
11	17	ADMIN. SAL - J. MEISELS	DIRECT/PATIENT DAYS		5	9,284	9,284		2,056	11
12	17	ADMIN. SAL. - STEVE VAN (	DIRECT/PATIENT DAYS		3	10,508	10,508			12
13	17	ADMIN. SAL. - MIKE FILIPP	PATIENT DAYS	258,551	8	88,849	88,849	40,778	14,013	13
14	19	PROFESSIONAL FEES	PATIENT DAYS	258,551	8	36,541		40,778	5,763	14
15	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	258,551	8	35,917		40,778	5,665	15
16	21	CLERICAL & GENERAL	PATIENT DAYS	258,551	8	459,219	364,702	40,778	72,427	16
17	21	ACCTG SAL-B. LARIMORE	DIRECT/PATIENT DAYS		7	35,710	35,710		5,729	17
18	21	OFFICE SAL-M. CLOCH	PATIENT DAYS	258,551	8	17,876	17,876	40,778	2,819	18
19	24	EDUCATION & SEMINAR	PATIENT DAYS	258,551	8	1,028		40,778	162	19
20	26	INSURANCE	PATIENT DAYS	258,551	8	121		40,778	19	20
21	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	258,551	8	152,231		40,778	24,010	21
22	30	DEPRECIATION	PATIENT DAYS	258,551	8	77,371		40,778	12,203	22
23	32	INTEREST	PATIENT DAYS	258,551	8	19,022		40,778	3,000	23
24	34	OFFICE RENT-UNRELATED	PATIENT DAYS	258,551	8	59,175		40,778	9,333	24
25	TOTALS					$ 1,635,956	$ 1,133,970		$ 258,891	25

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	EQUIPMENT RENTAL	PATIENT DAYS	258,551	8	$ 6,176	$	40,778	$ 974	1
2										2
3										3
4										4
5	6	REPAIRS AND MAINT.	PAINTING REVENUE	24,700	4	27,506	27,506	2,224	2,477	5
6	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	24,700	4	4,515		2,224	407	6
7										7
8	1	DIETICIAN SALARIES	DIETICIAN REVENUE	34,652	8	42,478	42,478	5,160	6,325	8
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	34,652	8	6,973		5,160	1,038	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 87,648	$ 69,984		$ 11,221	25

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	89,917	5	$ 5,150	$ 5,150	18,665	$ 1,069	1
2	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	89,917	5	16,467	16,467	18,665	3,418	2
3	17	ADMIN. SAL. - B. TEITELBA	PATIENT DAYS	89,917	5	11,667	11,667	18,665	2,422	3
4	17	ADMIN. SAL - J. MEISELS	PATIENT DAYS	89,917	5	4,800	4,800	18,665	996	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	89,917	5	1,316		18,665	273	5
6	17	MGNT FEES-DIRECT ALLO	DIRECT ALLOCATION		5	541,973			111,131	6
7	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	89,917	5	200		18,665	42	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	89,917	5	55,820		18,665	11,587	8
9	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	89,917	5	1,825		18,665	379	9
10	30	DEPRECIATION	PATIENT DAYS	89,917	5	8,999		18,665	1,868	10
11	32	INTEREST	PATIENT DAYS	89,917	5	6,900		18,665	1,432	11
12	36	GAIN ON SALE OF ASSETS	PATIENT DAYS	89,917	5	(17,809)		18,665	(3,697)	12
13										13
14										14
15										15
16										16
17	1	DIETICIAN SALARIES	DIETICIAN REVENUE	4,053	3	3,527	3,527	135	117	17
18	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	4,053	3	71		135	2	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 640,906	$ 41,611		$ 131,039	25

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	147,139	8	$ 2,034	$	18,655	$ 258	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	147,139	8	1,354		18,655	172	2
3	10	NURSING	PATIENT DAYS	147,139	8	6,902	5,142	18,655	875	3
4	10	SAL-NURSING-M. CLARKE	PATIENT DAYS	147,139	8	45,100	45,100	18,655	5,718	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	147,139	8	11,172		18,655	1,416	5
6	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	147,139	8	101,666	101,666	18,655	12,890	6
7	17	ADMIN. SAL.- F. BENJAMIN	PATIENT DAYS	147,139	8	80,400	80,400	18,655	10,194	7
8	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	147,139	8	57,937	57,937	18,655	7,346	8
9	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	147,139	8	68,004	68,004	18,655	8,622	9
10	17	ADMIN. SAL. - C. ROSS	DIRECT/PATIENT DAYS		4	4,050	4,050	18,655	1,021	10
11	17	ADMIN. SAL - S. VAN CAMP	PATIENT DAYS	147,139	8	50,000	50,000	18,655	6,339	11
12	17	ADMIN. SAL. - M. FILIPPO	PATIENT DAYS	147,139	8	61,604	61,604	18,655	7,810	12
13	17	ADMIN. SAL. - J. ELOWE	AVERAGE HOURS	10	3	12,210	12,210			13
14	19	PROFESSIONAL FEES	PATIENT DAYS	147,139	8	37,170		18,655	4,713	14
15	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	147,139	8	17,139		18,655	2,173	15
16	21	CLERICAL & GENERAL	PATIENT DAYS	147,139	8	311,878	242,119	18,655	39,541	16
17	21	SALARIES-ACCTG-B. LARIN	DIRECT/PATIENT DAYS		7	17,000	17,000	18,655	2,438	17
18	24	EDUCATION & SEMINAR	PATIENT DAYS	147,139	8	2,070		18,655	262	18
19	26	INSURANCE	PATIENT DAYS	147,139	8	13		18,655	2	19
20	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	147,139	8	149,543		18,655	18,960	20
21	30	DEPRECIATION	PATIENT DAYS	147,139	8	3,414		18,655	433	21
22	32	INTEREST	PATIENT DAYS	147,139	8	(39)		18,655	(5)	22
23	34	OFFICE RENT-UNRELATED	PATIENT DAYS	147,139	8	31,727		18,655	4,023	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	147,139	8	2,402		18,655	304	24
25	TOTALS					$ 1,074,750	$ 745,232		$ 135,505	25

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3	6	REPAIRS AND MAINT.	PAINTING REVENUE	8,632	2	7,120	7,120	520	429	3
4	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	8,632	2	1,583		520	95	4
5						$	$			5
6	1	DIETICIAN SALARIES	DIETICIAN REVENUE	19,790	8	20,524	20,524	1,950	2,022	6
7	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	19,790	8	4,564		1,950	450	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 33,791	$ 27,644		$ 2,996	25

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization AT&R II, LLC
Street Address 8950 GROSS POINT RD. #E
City / State / Zip Code SKOKIE, IL 60077
Phone Number (847)663-1155
Fax Number (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						4,283	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						482,837	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 487,120	25

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization ADVANCED THERAPY AND REHAB, LLC
Street Address 8950 GROSS POINT RD. #E
City / State / Zip Code SKOKIE, IL 60077
Phone Number (847)663-1155
Fax Number (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						2,058	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						198,454	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 200,512	25

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MEDICAL SUPPLY
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	MEDICAL/TUBE FEED-MDC	DIRECT ALLOCATION						7,691	1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						11,848	2
3	1	FOOD SUPPLEMENTS	DIRECT ALLOCATION						27,645	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 47,184	25

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Corus Bank		X	Mortgage	Varies	10/24/96	$ 1,200,000	$ 0	03/20/01	Prime+1.5	$ 20,401	1
2	American Charter		X	Mortgage	Varies	12/27/01	3,650,000	3,650,000	01/01/07	Prime+1.5	2,788	2
3	Corus Bank		X	Mortgage	Varies	3/20/01	3,570,000	0	12/27/01	Prime+1.5	191,533	3
4	Cananwill Inc.		X	Insurance	$7,284	7/1/01	139,794	0	1/1/02	8.22%	4,832	4
5	Viasys/Bird		X	Equipment purchase	$2,006	5/9/01		79,057	4/9/06	13.22%	6,447	5
	Working Capital											
6	Bank Leumi		X	Line of credit	Interest only	9/1/00	1,500,000	0	Demand		76,457	6
7	Bank Leumi		X	Line of credit	Varies	9/1/01	1,500,000	0	Demand		14,167	7
8	DVI		X	Line of credit	Interest only	10/15/01		1,664,709	Demand		27,336	8
9	TOTAL Facility Related				$9,290		$ 11,559,794	$ 5,393,766			$ 343,961	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										4,427	10
11	Interest income										(123,757)	11
12	Hill-Rom		X	Equipment purchase	$1,554	5/1/00	17,675	0	5/1/01	10.00%	190	12
13												13
14	TOTAL Non-Facility Related				$1,554		$ 17,675	$			$ (119,140)	14
15	TOTALS (line 9+line14)						$ 11,577,469	$ 5,393,766			$ 224,821	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Quality Care Management	X					$	$			$ 3,000	1
2	Quality Care Management	X									1,432	2
3	Boulevard Healthcare Mgmt	X									(5)	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 4,427	21

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	256,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	250,691	2
3. Under or (over) accrual (line 2 minus line 1).	$	(6,109)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	260,700	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	52,540	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	307,131	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	273,370	8
	1997	265,995	9
	1998	248,551	10
	1999	246,883	11
	2000	250,691	12

Calculation of 2001 accrual = 2000 tax $250,691 x 1.04 = $260,700 (rounded)

The real estate tax refund applies to years not used in calculating rates.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 200(	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULAT	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CONTINENTAL CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBEI 0022541

CONTACT PERSON REGARDING THIS REP(Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the porti cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of th home property which is vacant, rented to other organizations, or used for purposes other than long term care must entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-12-226-006	Long term care property	$ 216,954.21	$ 216,954.21
2.	13-12-226-007	Long term care property	$ 29,412.63	$ 29,412.63
3.	13-12-226-018	Long term care property	$ 4,324.44	$ 4,324.44
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 250,691.28	$ 250,691.28

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not d used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax b is normally paid during 2001.

Facility Name & ID Numb CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,288 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 45,569
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 9,055
4. Dates Incurred: _____

Nature of Costs: Line of credit and financing fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	108,000	1976	$ 356,000	1
2					2
3	TOTALS	108,000		$ 356,000	3

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1976	$ 2,130,000	$	35	$ 60,857	$ 60,857	$ 1,308,407	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1979	6,105		20	-		6,105	9
10	Various			1980	9,032		20	-		9,032	10
11	Various			1983	19,029		20	-		19,029	11
12	Various			1985	24,698		20	985	(985)	18,689	12
13	Various			1986	43,755		20	2,188	2,188	28,877	13
14	Various			1987	31,019		20	245	245	29,176	14
15	Various			1988	12,294		20	137	137	11,175	15
16	Various			1989	27,060		20	985	985	18,289	16
17	Various			1991	19,303		20	965	965	10,039	17
18	Various			1992	2,934		20	293	293	2,784	18
19	Various			1993	11,866		20	594	594	5,206	19
20	Various			1994	38,563		20	2,094	2,094	15,566	20
21	Various			1995	54,419		20	2,721	2,721	19,059	21
22	Various			1996	65,777		20	2,962	2,962	16,124	22
23	Various			1997	16,158		20	808	808	3,508	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		-	-		-		-	68
69	Financial Statement Depreciation			162,695			(162,695)		69
70	TOTAL (lines 4 thru 69)		$ 2,512,012	$ 162,695		$ 75,834	$ (88,831)	$ 1,521,065	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,512,012	$ 162,695		$ 75,834	$ (86,861)	$ 1,521,065	1
2	EXHAUST FAN	1998	1,950		20	98	98	392	2
3	WIRING	1998	1,007		20	50	50	200	3
4	PUMP MOTOR	1998	1,232		20	62	62	248	4
5	FIRE ALARM WIRING	1998	4,141		20	207	207	828	5
6	FIRE ALARM SYSTEM	1998	3,872		20	194	194	776	6
7	WIRING	1998	1,128		20	56	56	224	7
8	CHILLER	1998	89,800		20	4,490	4,490	16,463	8
9	FIRE DAMPER	1998	607		20	30	30	108	9
10	WIRING	1998	563		20	28	28	100	10
11	INSULATE PIPES	1998	736		20	37	37	133	11
12	WATER METER	1998	1,797		20	90	90	323	12
13	REHAB CLOSET	1998	942		20	47	47	165	13
14	FIRE DAMPERS	1998	1,200		20	60	60	205	14
15	WINDOWS	1998	2,010		20	101	101	337	15
16	WATERPROOFING	1998	12,900		20	645	645	1,989	16
17	EXHAUST FAN MOLRS	1998	714		20	36	36	111	17
18	Z WALLACH	1998	2,436		20	122	122	376	18
19	EXHAUST SYSTEMS	1998	3,644		20	182	182	561	19
20	WIRING	1998	3,698		20	185	185	570	20
21	WIRING	1998	1,677		20	84	84	259	21
22	PAINTING & DECOR	1998	6,788		20	339	339	1,187	22
23	REPACK FIRE PUMP	1998	825		20	41	41	154	23
24	COUNTER TOP HINGES	1998	2,567		20	128	128	416	24
25	FIRE SYSTEM	1998	1,949		20	97	97	299	25
26	FIRE ALARM SYSTEM	1998	32,750		20	1,638	1,638	4,914	26
27	CARPET & INSTALL	1999	2,088		20	104	104	295	27
28	FIRE DAMPERS	1999	29,600		20	1,480	1,480	4,193	28
29	INSULATION BOILER	1999	1,297		20	65	65	184	29
30	INSTALL FLOORING	1999	1,847		20	92	92	238	30
31	INFRARED DOOR DETECT	1999	4,300		20	215	215	555	31
32	THEROTECH	1999	2,657		20	133	133	333	32
33	INST.FUEL TANK 50%	1999	4,293		20	215	215	466	33
34	TOTAL (lines 1 thru 33)		$ 2,739,027	$ 162,695		$ 87,185	$ (75,510)	$ 1,558,667	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,739,027	$ 162,695		$ 87,185	$ (75,510)	$ 1,558,667	1
2	DOOR ALARMS	1999	2,273		20	114	114	333	2
3	PAINTING & DECORATIN	1999	7,683		20	384	384	960	3
4	HVAC-MOTOR & DISCONN	1999	808		20	40	40	113	4
5	EXPLOSION PROOF BRAC	1999	1,072		20	54	54	149	5
6	COOLING TOWER BEARIN	1999	1,575		20	79	79	217	6
7	INSTALL DOOR CLOSER	1999	610		20	31	31	85	7
8	REPLACE CONN.OVEN DO	1999	1,245		20	62	62	171	8
9	B & G BEARING ASSEMB	1999	698		20	35	35	93	9
10	REPAIR COOLING TOWER	1999	1,165		20	58	58	155	10
11	REPLACE H20 PUMPSEAL	1999	576		20	29	29	77	11
12	REPAIR FIRE ALARM SY	1999	870		20	44	44	117	12
13	EJECTOR PUMP PARTS	1999	1,546		20	77	77	199	13
14	REPAIR NURSE CALL SY	1999	843		20	42	42	109	14
15	INSTALL LIGHTS IN OX	1999	920		20	46	46	115	15
16	MOTORIZED DAMPER	1999	1,498		20	75	75	181	16
17	PATIO DOOR TEMPERED	1999	513		20	26	26	63	17
18	DOOR HINGE & REINFOR	1999	727		20	36	36	81	18
19	INSTALL HVAC PIPING	1999	550		20	28	28	63	19
20	INSTALL DOOR HINGE	1999	2,730		20	137	137	297	20
21	INSTALL SPRINKLER	1999	735		20	37	37	80	21
22	REPAIR CALL SYST	1999	1,528		20	76	76	222	22
23	LOCKS	1999	1,681		20	84	84	245	23
24	LANDING GATES&HANDRA	1999	978		20	49	49	147	24
25	SATELLITE SYSTEM	2000	40,000		20	9,796	9,796	15,511	25
26	FIRE DAMPERS	2000	31,000		20	795	795	1,557	26
27	ELECTRICAL WIRING	2000	6,272		20	161	161	315	27
28	25 DOORS	2000	3,942		20	1,261	1,261	2,050	28
29	ELECTRIC WIRING	2000	798		20	20	20	38	29
30	II ACCESS DOORS	2000	1,986		20	636	636	1,033	30
31	ELECTRIC WIRING	2000	1,695		20	43	43	66	31
32	FENCE	2000	511		20	49	49	75	32
33	INSTALL BREAKER	2000	2,832		20	73	73	106	33
34	TOTAL (lines 1 thru 33)		$ 2,860,887	$ 162,695		$ 101,662	$ (61,033)	$ 1,583,690	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,860,887	$ 162,695		$ 101,662	$ (61,033)	$ 1,583,690	1
2	FIRE GUARD TANK	2000	6,381		20	164	164	253	2
3	PUSH BUTTON LOCKS	2000	583		20	186	186	303	3
4	ELECTRIC WIRING	2000	12,475		20	320	320	413	4
5	ELECTRIC TRANSFER	2000	11,246		20	288	288	348	5
6	REMOVE FUEL TANK	2000	2,462		20	178	178	271	6
7	INSTALL MIRROR	2000	1,957		20	626	626	1,018	7
8	REHAB ROOM	2000	1,392		20	36	36	44	8
9	ELECTRIC REHAB ROOM	2000	1,650		20	42	42	47	9
10	WIRING KITCHEN	2000	769		20	20	20	23	10
11	INSTALL PHONES	2000	743		20	37	37	37	11
12	PAINTING AND DECORATING	2000	1,284		20	64	64	64	12
13	BLINDS	2000	662		20	33	33	33	13
14	BOILER HEAT EXCHANGE	2000	4,950		20	248	248	248	14
15	REPLACE SPRINKLER SY	2001	825		20	41	41	41	15
16	FIRE ALARM PANEL	2001	995		20	50	50	50	16
17	PLUMBING	2001	778		20	39	39	39	17
18	INSTALL PHONE LINES	2001	1,171		20	49	49	49	18
19	EXHAUST SYSTEM	2001	2,500		20	104	104	104	19
20	ELECTRICAL OUTLETS	2001	775		20	29	29	29	20
21	FIRE DOORS INST.	2001	970		20	33	33	33	21
22	HEAT EXCHANGER	2001	4,950		20	165	165	165	22
23	BOILER PIPE INST.	2001	1,120		20	37	37	37	23
24	CHAIN LINK FENCE	2001	988		20	33	33	33	24
25	FIRE DAMPERS INSTALL	2001	2,908		20	73	73	73	25
26	REWIRE PUMP MOTOR	2001	1,598		20	7	7	7	26
27	REPLACE EXHAUST MOTO	2001	1,087		20	5	5	5	27
28	ELECTRICAL WIRING	2001	1,496		20	6	6	6	28
29	CUSTOM DRAPERIES	2001	1,919		20	96	96	96	29
30	LIFE ALARM KEYBOARD	2001	1,394		20	70	70	70	30
31	ROOFTOP EXHAUST	2001	609		20	30	30	30	31
32	REFRIGERATOR WORK	2001	508		20	25	25	25	32
33	WROUGHT IRON FENCE	2001	980		20	49	49	49	33
34	TOTAL (lines 1 thru 33)		$ 2,935,012	$ 162,695		$ 104,845	$ (57,850)	$ 1,587,733	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,935,012	$ 162,695		$ 104,845	$ (57,850)	$ 1,587,733	1
2	EJECTOR PUMP PARTS	2001	1,968		20	98	98	98	2
3	FIRE ALARM PARTS	2001	513		20	26	26	26	3
4	LIFE ALARM	2001	1,962		20	98	98	98	4
5	VALVE WORK	2001	909		20	45	45	45	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,940,364	$ 162,695		$ 105,112	$ (57,583)	$ 1,588,000	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,940,364	$ 162,695		$ 105,112	$ (57,583)	$ 1,588,000	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,940,364	$ 162,695		$ 105,112	$ (57,583)	$ 1,588,000	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,940,364	$ 162,695		$ 105,112	$ (57,583)	$ 1,588,000	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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17									17
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,940,364	$ 162,695		$ 105,112	$ (57,583)	$ 1,588,000	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,940,364	$ 162,695		$ 105,112	$ (57,583)	$ 1,588,000	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,940,364	$ 162,695		$ 105,112	$ (57,583)	$ 1,588,000	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,940,364	$ 162,695		$ 105,112	$ (57,583)	$ 1,588,000	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,940,364	$ 162,695		$ 105,112	$ (57,583)	$ 1,588,000	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A-REP, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 560,874	$ 14,071	$ 67,516	$ 53,445	10	$ 329,854	71
72	Current Year Purchases	112,175	433	5,467	5,034	10	5,467	72
73	Fully Depreciated Assets	542,649				10	542,649	73
74								74
75	TOTALS	$ 1,215,698	$ 14,504	$ 72,983	$ 58,479		$ 877,970	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1982 FORD	1982	$ 14,556	$	$	$	5	$ 12,000	76
77	Facility	1986 VAN	1986	15,916				5	15,916	77
78	Facility	USED VAN	1988	3,000				5	3,000	78
79										79
80	TOTALS			$ 33,472	$	$	$		$ 30,916	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,545,534	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 177,199	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 178,095	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 896	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,496,886	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Building	$ 245,140	92
93			93
94			94
95		$ 245,140	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Quality Care Management Allocation				9,333			5
6	Boulevard Healthcare Mgmt Allocation				4,023			6
7	TOTAL				$ 13,356 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the curre
    rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 10,976 Description: See attached schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income you facility received training aides from other facilities

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 44,640	$		$ 44,640	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			11,383			11,383	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			692,748			692,748	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				106,856		106,856	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):			153,383		164,540	237,808		555,731	13
14	TOTAL			$ 153,383		$ 913,311	$ 344,664		$ 1,411,358	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,329	$	1
2	Cash-Patient Deposits	52,608		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,464,473		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,980		6
7	Other Prepaid Expenses	31,120		7
8	Accounts Receivable (owners or related parties)	3,010,694		8
9	Other(specify): See supplemental schedule	220,792		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,853,996	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	486,000		13
14	Buildings, at Historical Cost	2,130,000		14
15	Leasehold Improvements, at Historical Cost	603,900		15
16	Equipment, at Historical Cost	1,321,080		16
17	Accumulated Depreciation (book methods)	(2,497,706)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	45,569		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	245,140		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,333,983	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,187,979	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 969,042	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	52,510		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	79,690		30
31	Accrued Taxes Payable (excluding real estate taxes)	45,093		31
32	Accrued Real Estate Taxes(Sch.IX-B)	260,700		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,843		35
	Other Current Liabilities(specify):			
36	See supplemental schedule	5,537		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,422,415	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,743,766		39
40	Mortgage Payable	3,650,000		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify)			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,393,766	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,816,181	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,371,798	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,187,979	$	48

*(See instructions.)

Facility Name & ID Numbe CONTINENTAL CARE CENTER # 0022541 Report Period Beginning:01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,428,183	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-**	$ 1,428,183	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	543,615	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(600,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (56,385)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,371,798	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Numb CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,502,447	1
2	Discounts and Allowances for all Levels	(1,579,689)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,922,758	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,480,857	6
7	Oxygen	196,762	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,677,619	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	232,718	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,934	19
20	Radiology and X-Ray	230	20
21	Other Medical Services	85,898	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$ 350,780	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	141,155	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 141,155	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See supplemental schedule	69,704	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 69,704	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 9,162,016	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,233,696	31
32	Health Care	2,938,174	32
33	General Administration	2,115,966	33
	B. Capital Expense		
34	Ownership	780,190	34
	C. Ancillary Expense		
35	Special Cost Centers	1,436,495	35
36	Provider Participation Fee	113,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,618,401	40
41	**Income before Income Taxes (line 30 minus line 40)****	543,615	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus lin**	$ 543,615	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,397	1,727	$ 54,053	$ 31.30	1
2	Assistant Director of Nursing	416	440	10,154	23.08	2
3	Registered Nurses	26,998	30,229	682,985	22.59	3
4	Licensed Practical Nurses	22,617	24,228	442,927	18.28	4
5	Nurse Aides & Orderlies	90,792	95,582	871,640	9.12	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,404	7,605	153,383	20.17	7
8	Rehab/Therapy Aides	7,368	8,325	100,336	12.05	8
9	Activity Director	1,809	1,993	23,087	11.58	9
10	Activity Assistants	6,451	7,134	49,293	6.91	10
11	Social Service Workers	5,021	5,602	71,125	12.70	11
12	Dietician					12
13	Food Service Supervisor	1,819	2,091	50,066	23.94	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,543	32,438	221,228	6.82	15
16	Dishwashers					16
17	Maintenance Workers	3,815	4,451	74,030	16.63	17
18	Housekeepers	22,488	24,030	166,872	6.94	18
19	Laundry	10,197	10,952	73,989	6.76	19
20	Administrator	1,901	2,484	90,476	36.42	20
21	Assistant Administrator	1,437	1,526	32,333	21.19	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,872	16,241	187,057	11.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,705	1,884	23,294	12.36	31
32	Other Health Care(specify)					32
33	Other(specify)	997	1,046	25,137	24.03	33
34	TOTAL (lines 1 - 33)	259,047	280,008	$ 3,403,465 *	$ 12.15	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	455	$ 13,657	01-03	35
36	Medical Director	198	19,800	09-03	36
37	Medical Records Consultant	66	2,640	10-03	37
38	Nurse Consultant		3,250	10-03	38
39	Pharmacist Consultant	225	7,880	10-03	39
40	Physical Therapy Consultant	71	3,263	10a-03	40
41	Occupational Therapy Consultant	85	4,343	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,444	11-03	44
45	Social Service Consultant	42	2,067	12-03	45
46	Other(specify)				46
47	WOUND CARE CONSULTANT	69	3,250	10a-03	47
48	Religious consultant	Monthly	250	12-03	48
49	TOTAL (lines 35 - 48)	1,259	$ 62,844		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	6,352	$ 240,991	10-03	50
51	Licensed Practical Nurses	2,984	98,244	10-03	51
52	Nurse Aides	59	4,460	10-03	52
53	TOTAL (lines 50 - 52)	9,395	$ 343,695		53

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Monica Ramirez (1/1-5/18/01)	Administrator	0	$ 50,339
John Gutstein (10/1-12/31/01)	Administrator	0	15,050
Diane Schmidt (9/1-12/31/01)	Asst. Administrator	0	14,742
Cindy Green (1/1-5/1/01)	Asst. Administrator	0	17,591
Cindy Green (5/1-9/1/01)	Administrator	0	25,087
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 122,809

B. Administrative - Other

Description	Amount
David Meisels-Management fees	$ 60,000
Quality Care Management-Management fees	532,309
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 592,309

C. Professional Services

Vendor/Payee	Type	Amount
See attached schedule	Legal	$ 57,526
Frost Ruttenberg & Rothblatt	Accounting	19,995
Documentation solutions	Professional fees	105
Appraisal Research Counselors	Appraisal services	4,200
Personnel Planners	Unemployment tax consultan	1,200
JCAHO consultant	Accreditation	3,000
Econocare	Purchasing consultant	1,423
Lionheart Engineering P.C.	Engineering	414
Commitment Consulting	Consulting	2,462
See attached schedule	Computer services	20,144
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 110,469

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,198
Unemployment Compensation Insurance	28,772
FICA Taxes	255,302
Employee Health Insurance	139,104
Employee Meals	31,755
Illinois Municipal Retirement Fund (IMRF)*	
401k expense	12,313
Employee benefits/holiday expense	11,510
Union pension expense	21,997
Life insurance	871
Head tax	7,713
TOTAL (agree to Schedule V, line 22, col.8)	$ 566,535

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	41,206
Health Care Worker Background Check (Indicate # of checks performe 100)	1,000
Dues/licenses	10,958
Yellow page advertising	6,291
Advertising and promotion	57,969
Classified advertising	21,124
Quality Care/Boulevard allocation	7,880
Less: Public Relations Expense	
Non-allowable advertising	(57,969)
Yellow page advertising	(6,291)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 82,568

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,709
Quality Care Management allocation	162
Boulevard Healthcare Mgmt allocation	262
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,133

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Numbe CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost repo **Yes**
If YES, give association name and amou **Illinois Council on LTC $10,020**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this peri **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. **2,060** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangemen **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII) YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. **113,880**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Sectio **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **31,755** Has any meal income been offset against related costs? **No** Indicate the amount $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportatio residents? **No** If YES, please indicate the amount of income earned from such program during this reporting period. **N/A**
c. What percent of all travel expense relates to transportation of nurses and pati **100% In14**
d. Have vehicle usage logs been maintain **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting f **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this cop been attached? _____ If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost repor **Yes**
Attach invoices and a summary of services for all architect and appraisal fees